

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH: *Mission*  
 County *Mission*  
 City or town *Mission*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *10 months*  
 Hospital, Institution or street address where death occurred:  
*Bradley St.*  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Md.* County *Mission*  
 City or town *Mission*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *Bradley St.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

3. (a) FULL NAME *George Francis Bailey*

3. (b) Social Security Number  
*715-76-3974*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*  
 6. (b) Name of husband or wife *May Lea Bailey*  
 6. (c) If alive, give age *68* years  
 7. Birth date of deceased (mo., day, yr.) *Nov. 31, 1876*  
 8. AGE: Year *71* Months *7* Days *4* If less than one day  
 hrs. min.

9. Birthplace *Shurtis, Mission, Md.*  
 (Town, county, and state)  
 10. Usual occupation *Farmer*  
 11. Industry or business

12. Name *Marillac Bailey*  
 13. Birthplace *Mission Co., Md.*  
 14. Maiden name *May Bradley*  
 15. Birthplace *Mission Co., Md.*

16. Informant *Mr. G. Edwin Bailey*  
 Address *Salisbury, Md. R.R. 2*  
 17. *Burial* Date thereof *3/7/48*  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium *Mission Memorial Park*  
 Location *Salisbury, Md.*  
 18. Funeral director *The Hill Funeral Co.*  
 Address *Salisbury, Md.*

19. *3/7* 19*48* *Married G. Johnson*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 5, 1948* at *4:30 A.M.*  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 27, 1948* to *Mar 5, 1948*  
 and that I last saw him alive on *March 5, 1948*

Immediate cause of death *hemiplegia* DURATION

Due to *Fractured leg*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations *Fractured leg* Date of op. *Feb 11/48*

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide *Accident* Date of *1/27/48*

Where did injury occur? *Salisbury, Md.* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Home*

Means of injury *Fall* Injured at work? *NO*

23. SIGNATURE *D. M. Hunt* M. D. or other  
 Address *Salisbury* Date signed *3/8/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this certificate are especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 298

## 1. PLACE OF DEATH:

County Hicomicus  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Minicula General Hospital  
 How long in hospital or institution? 3 days 18 hrs. 55 min.

## 3. (a) FULL NAME

Barratt, Phillip JEFFREY

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

014

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date reg'd by registrar)

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## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 24 1948 at 4:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 March 1948 to 24 March 1948and that I last saw him alive on 24 March 1948

Immediate cause of death

Acute B. infectiois dialis

DURATION

4 days

Due to

organism not determined

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Richard M. D.

M. D. or other

Address

Salisbury, Md.Date signed 3/25/48

**RECEIVED**

APR 13 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of

age shown on:

RUM No. G

115 APR 20 1948

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1046

03210

Reg. Dist. No. 333

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 hrs  
 Hospital, institution, or street address where death occurred:  
Peninsula General Hospital  
 How long in hospital or institution? 30 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 505 Laurel St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Beauchamp, Marie MARY

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6.(a) Single, married, widowed, or divorced

single

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

July 18 - 1931

## 6.(c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years 16 Months 11 Days 12  
 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

(Town, county, and state),

## 10. Usual occupation

School girl

## 11. Industry or business

FATHER

## 12. Name

Charles Beauchamp

## 13. Birthplace

md

MOTHER

## 14. Maiden name

Abie Dickerson

## 15. Birthplace

md

## 16. Informant

Charles Beauchamp

## Address

md

## 17.

(Burial, cremation, or removal. Which?)

BurialDate thereof March 30, 1948  
(month) (day) (year)

## Cemetery or crematory

Tindley Chapel

## Location

Rural Pocomoke md

## 18. Funeral director

Johnny McDaniel

## Address

Pocomoke md

## 19.

3/30/48  
(Date rec'd by registrar)Barry J. Johnson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 48 at 11:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 25 19 48 to March 27 19 48  
and that I last saw him alive on March 27 19 48

Immediate cause of death

Meningitis, Bacterial

## DURATION

6 days

Due to

Cerebral Sinus7 days

Due to

(Septic) Thrombosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David Gilmore Jr. D.  
Address Salisbury md

M.D. or other

Apr 28 1948  
Date signed

**RECEIVED**

APR 13 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Micromis  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 80 years  
 Hospital, institution, or street address where death occurred:  
304 Charles St.  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Micromis  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 304 Charles St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Charles C. Barrett

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower  
 6. (b) Name of husband or wife Lena E. Barrett  
 7. Birth date of deceased (mo., day, yr.) March 8, 1867  
 6. (c) If alive, give age..... years

8. AGE: Years 80 Months 11 Days 13 If less than one day..... hrs. .... min.

9. Birthplace Salisbury, Micromis, MD  
 (Town, county, and state)

10. Usual occupation Real Estate Broker

## 11. Industry or business

12. Name John D. Barrett  
 13. Birthplace Micromis Co. MD  
 14. Maiden name Biddie Smith  
 15. Birthplace Micromis Co. MD

16. Informant Mrs. Grace D. Randall  
 Address 304 Charles St., Salisbury, MD

17. Burial Date thereof 3/11/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lawson  
 Location Salisbury, MD

18. Funeral director W. V. H. H. H. Co.  
 Address Salisbury, MD

19. 3/11 19 48 Warrant E. Johnson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1948 at 7 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased and that I last saw him in his home on March 1, 1948  
 Immediate cause of death.....

coronary occlusion  
 Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)  
 Major findings of operations none Date of op.....

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE Latademaier M.D.  
Deputy Medical Examiner  
 M. D. or other.....  
 Address Salisbury, MD Date signed 3/2/48

03212

**RECEIVED**

MAR 12 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

832

03211

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Laura Benson

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

(Not Known) 1888

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

60

hrs.

min.

9. Birthplace

Princess Anne, Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

FATHER

12. Name

Samuel King

13. Birthplace

Princess Anne, Md.

MOTHER

14. Maiden name

Rosa Newman

15. Birthplace

Somerset Co.

16. Informant

Elyah Benson

Address

Princess Anne, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

37 7-1948

(month) (day) (year)

Cemetery or crematory

John Wesley

Location

Princess Anne, Md.

18. Funeral director

William H. James Jr.

Address

Princess Anne, Md.

19.

3/6, 1948

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## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4<sup>th</sup> 1948 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

3/2 1948 to 3/4 1948  
and that I last saw him alive on 3/3 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 days

Due to

Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE

Clara E. Fisher

M. D. or other

Address Salisbury Md. Date signed 3/4 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 12 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

158

03213

## CERTIFICATE OF DEATH

Reg. Dist. No. 383

## 1. PLACE OF DEATH:

County SevierCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Sevier General HospitalHow long in hospital or institution? 15 days 22 hrs 50 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SevierCity or town Berlin Rd. # 2  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Brissell, Gladys

## 3. (b) Social Security Number

4. Sex F 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife no 6. (c) If alive, give age no years7. Birth date of deceased (mo., day, yr.) 19228. AGE: Years 26 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Berlin, Md.  
(Town, county, and state)10. Usual occupation worked at home11. Industry or business same as above12. Name James H. Baker13. Birthplace Berlin14. Maiden name Unknown15. Birthplace Unknown16. Informant Martha A. HorneAddress Synagogue andBerlin17. (Burial, cremation, or removal, Which?) Burial Date thereof Mar 31, 1948  
(month) (day) (year)Cemetery or crematory SynagogueLocation Berlin18. Funeral director James H. BakerAddress Salisbury, Md.19. 5/31 1948 James H. Baker Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948 at 9:10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1948 to March 29, 1948and that I last saw him alive on March 29 1948

Immediate cause of death

PemphigusDue to Pemphigus

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

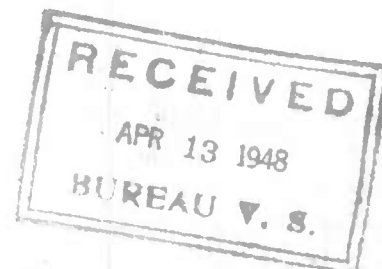
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James H. Baker M. D. or otherAddress Salisbury, Md. Date signed 3-29-48



Dr. Long - Bricle

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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03214

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital  
How long in hospital or institution? 15 days, 16 hrs. 45 mins.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Snow Hill  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2. (a) If veteran, name war \_\_\_\_\_ no ✓

## 3. (a) FULL NAME

Brittingham, Mrs. Helen L.

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Lloyd F. Brittingham

7. Birth date of deceased (mo., day, yr.)

Feb. 15 - 18956. (c) If alive, give age 65 years

8. AGE:

Years

Months

Days

If less than one day

53110hrs.min.

9. Birthplace

Salisbury, Worcester, Md  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (a) Burial, cremation, or removal, which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19 48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th 19 48, at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3.9.1 19 48, to 3.25 19 48and that I last saw her alive on 3.24 19 48Immediate cause of death Chronic  
Chalrypides + chalythones years

DURATION

Due to

Due to

Other conditions Hypertensive cardio  
vascular disease, chronic years

(Include pregnancy within 7 months of death)

Major findings of operations Chalrypides +  
chalythones Date of op. 3.13.48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide, \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. Bricle

M. D. or other

Address 405 N. Union St. Date signed 3.25.48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1948

BUREAU V. S.

Evidence for change of  
birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

03215

FILE NO. G 115 MAY 10 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Arco -  
City or town Mardela  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 yrs  
Hospital, institution, or street address where death occurred:  
RD #2  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Arco -  
City or town Mardela  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. RD #2  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

George Creighton Campbell

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 6 - 1894 1893

8. AGE: Years 54 Months 6 Days 20 If less than one day  
hrs. min.

9. Birthplace Georgetown Del.  
(town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Irish Campbell

13. Birthplace Georgetown Del.

14. Maiden name Mary Wingate

15. Birthplace Georgetown Del

16. Informant Mrs Katie Alexander

Address RD #2 Mardela Md

17. Burial (Burial, cremation, or other) Buried Date thereof March 28 - 48  
(month) (day) (year)

Cemetery or crematory Alfred Baptist Cem

Location Arco Md

18. Funeral director Hillman & Co. Walter R. Hillman

Address Salisbury Md

19. 3/18/48 19  
(Date rec'd by registrar)

W. H. Robertson  
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 - 48 19 48 at 230 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 - 48 to One week - 48  
and that I last saw him alive on March 25 - 48 19

Immediate cause of death On Cornea, yellowing DURATION  
severe epileptic seizure

Due to An epileptic

Due to  
Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter R. Hillman M. D. or other

Address Mardela Springs Md Date signed March 26 - 48

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

VS/A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1948

BUREAU V. S.



Dr. Moyer

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

03216

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 58 days 12 hrs. 40 mins.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Shapton - Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Shapton - Laurel Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Casper, Angeline

## 3. (b) Social Security Number

214-28-34324. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife Golden W. Casper6. (c) If alive, give age 29 years7. Birth date of deceased (mo., day, yr.) December 3, 19218. AGE: Years 26 Months 3 Days 8 If less than one day  
..... hrs. .... min.9. Birthplace Sussex County, Delaware  
(Town, county, and state)10. Usual occupation Housework11. Industry or business Home12. Name Ernest Deshields13. Birthplace Mardella Springs, Maryland14. Maiden name Lue Fook15. Birthplace Sussex County, Delaware16. Informant Golden W. CasperAddress Shapton, Maryland17. Burial Date thereof March 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Shiloh CemeteryLocation Near Shapton, Maryland18. Funeral director J. J. Fraughton & SonAddress Federalburg, Maryland19. 3/14 19 48 W. J. Johnson  
(Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 11th 19 48 at 11 55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/1 19 48 to 3/11 19 48and that I last saw her alive on 3/11/48Immediate cause of death Cerebral Hemorrhage

DURATION

3.8 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Moyer MDAddress Laurel Rd M. D. or otherDate signed 3/17/48

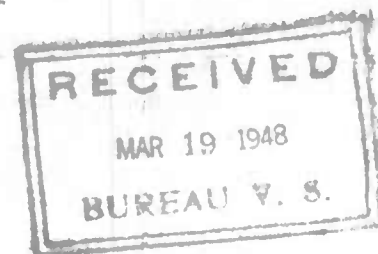
MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46.6

03217

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

### 1. PLACE OF DEATH:

County Wisconsin

City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 14 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Accomack

City or town Chincoteague  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Carpenter Mr. John

### 3. (b) Social Security Number

227-34-3097

4. Sex male 5. Color or race white 6.(a) Single, married, or divorced married

6.(b) Name of husband or wife Carpenter Mrs. Annie

7. Birth date of deceased (mo., day, yr.) July 14 1882

6.(c) If alive, give age 59 years

8. AGE: Years 65 Months 8 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chincoteague Va  
(Town, county, and state)

10. Usual occupation Chicken Raiser

11. Industry or business \_\_\_\_\_

12. Name William Carpenter

13. Birthplace Chincoteague Va

14. Maiden name Nancy Williams

15. Birthplace Chincoteague Va

16. Informant Mrs. Annie Carpenter

Address Chincoteague Va

17. Burial Date thereof March 25 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mechanics

Location Chincoteague Va

18. Funeral director Walter M. Clark

Address Chincoteague Va

19. 3/24 19 48 Barrett L. Johnson  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948 at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-9 19 48, to March 22 19 48

and that I last saw him alive on March 22 19 48

Immediate cause of death Carcinoma of stomach

DURATION 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Surgical shock 3 days

(Include pregnancy within 3 months of death)

Major findings of operations Metastases to esophagus & retroperitoneal nodes Date of op. 2/19/48

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE SA Rademacher MD M. D. or other \_\_\_\_\_

Address Salisbury Md Date signed 3/22/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County AccomackCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County AccomackCity or town Hallwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Chesser, Mr. John Fletcher

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 29, 18978. AGE: Years 50 Months 5 Days 1 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Hallwood, Accomack, Va.  
(Town, county, and state)10. Usual occupation Painter

11. Industry or business

12. Name Sevel Chesser13. Birthplace Atlantic, Va.14. Maiden name Missouri Bailey15. Birthplace Messongs, Va.16. Informant Samuel ChesserAddress Pocomoke City, Md.17. Burial Date thereof March 21, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Gallop CemeteryLocation Hallwood, Va.18. Funeral director J. D. Johnson Inc.Address Parkley, Va.19. 3/21/48 19 48 Barbara B. Johnson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 48 at 7:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/11/48 19 48 to 3/18/48 19 48 and that I last saw him alive on 3/18/48 19 48Immediate cause of death Myocardial Infarction  
Coronary artery disease DURATION 1 week

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy with \_\_\_\_\_ months of death)

Major findings of operations Lungs Date of op. 3/15/48Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. D. Johnson M. D. or otherAddress Parkley, Va. Date signed 3/18/48

**RECEIVED**

APR 2 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03219

Reg. Dist. No. 11-336

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Delmar  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 yrs  
 Hospital, institution, or street address where death occurred:  
R 420 #3  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Wicomico  
 City or town Delmar  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R 420 #3  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

William F. Cocron

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 26, 1921 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 26 Months 10 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Philadelphia, Pa.  
 (Town, county, and state)

10. Usual occupation Father

11. Industry or business Farm

12. Name John Cocron

13. Birthplace Hungary

14. Maiden name Margaret Boguel

15. Birthplace Hungary

16. Informant John Cocron

Address Delmar, Del R 420 #3

17. Burial Date thereof 3-13-48  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery Delmar

Location Delmar

18. Funeral director W. H. Mary O

Address Delmar, Del.  
March 13, 1948 Harry E. Hudson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1948, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1, 1948, to Mar 11, 1948

and that I last saw him living on Mar 11, 1948

Immediate cause of death Philipian's syndrome DURATION 20 yrs  
with cardiac failure

Due to Philipian's

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE H. E. Hudson M. D. or other

Address Delmar, Del. Date signed Mar 12/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 16 1948

**BUREAU V. S.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

03220

## CERTIFICATE OF DEATH

Reg. Dist. No. 993

## 1. PLACE OF DEATH:

County McComick  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Lincoln Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For birthplace, give residence of mother)  
 State Md. County McComick  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Lincoln Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Marion D. Collins

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Betha F. Collins  
 7. Birth date of deceased (mo., day, yr.) March 14, 1872 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 76 Months 0 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Parramatta, Md.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Mitchell Collins13. Birthplace P.O. Delmar Md.14. Maiden name Martha Mills15. Birthplace P.O. Delmar Md.16. Informant Mrs. Betha F. CollinsAddress Lincoln Ave, Salisbury Md17. (Burial, cremation, or removal, which?) Buried Date thereof (month) (day) (year) March, 31, 48Cemetery or crematory Lincoln Ave.Location Salisbury Md18. Funeral director William G. Walter & SonAddress Salisbury Md.19. 3/31/48 19 48 Registrar Walter

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1948 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death gunshot wound of abdomen DURATION sudden death

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations none

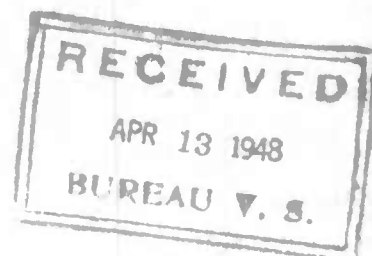
Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 3/28/48Where did injury occur? Salisbury Wicomico Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury shot himself with shotgun Injured at work? No23. SIGNATURE Walter Salisbury Md M. D. or otherAddress Salisbury Md Date signed 3/31/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14025

## CERTIFICATE OF DEATH

03221

Reg. Dist. No. 333

1. PLACE OF DEATH *McComie*  
County *Salisbury*  
City or town *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
*P.B. Hopt.*  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State *MD.* County *McComie*  
City or town *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *108 W.* *Philadelphia, Pa.*  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME *Virginia Bell Crisp* 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) *Feb. 6 - 1930* 6. (c) If alive, give age years

8. AGE: Years *18* Months *0* Days *27* If less than one day min.

9. Birthplace *Salisbury Md.*  
(Town, county and state)

10. Usual occupation *School Girl*

11. Industry or business

12. Name *Dan H. Crisp*

13. Birthplace *Salisbury Md.*

14. Maiden name *Elitha Miller*

15. Birthplace *New Rochelle N.Y.*

16. Informant *Mr. Dan H. Crisp*

Address *108 W. Phila. Ave. Salisbury Md.*

17. Burial, cremation, or removal. Which? *Burial* Date thereof *Mar. 16 - 1948*  
(month) (day) (year)

Cemetery or crematorium *McComie Mem Park.*

Location *Salisbury Maryland*

18. Funeral director *Hollingsworth & Walter R. Hollingsworth*

19. *3/16* 19. *3/16* Registrar *W. J. Johnson*

### MEDICAL CERTIFICATION

20. DATE OF DEATH *March 3rd 1948 8:10 P.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *medical* to *death* and that I last saw *him* alive on *Mar. 3rd* 1948

Immediate cause of death *Past abortion* *sepsis*

Due to *self-induced abortion* *3rd month*

Due to

Other conditions *Erysipelas - Left* *2 weeks*

(Include pregnancy within 3 months of death)

Major findings of operations *none*

Date of op.

Autopsy results *sepsis, subleptobiosis Erysipelas*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *no*

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *paradoxa* Injured at work?

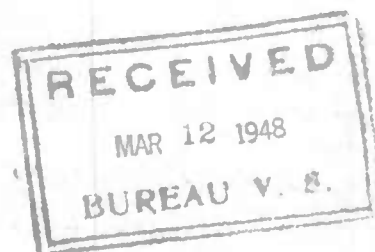
23. SIGNATURE *Deputy Medical Examiner* M. D. or other *3/4/48*  
Address *Salisbury Md.* Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03222

Reg. Dist. No.

337

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Tyaskin  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Wicomico  
 City or town Tyaskin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James E. H. Washiell

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

col.

6.(a) Single, married, widowed, or divorced

widower

6.(b) Name of husband or wife

Cora Barclay

7. Birth date of deceased (mo., day, yr.)

March 18, 1875

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

73-7

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace

Tyaskin, Wicomico, Md  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Jerry M. Washiell

13. Birthplace

Tyaskin, Md.

14. Maiden name

Louisa Horner

15. Birthplace

Tyaskin, Md.

16. Informant

Clifton Washiell

Address

Tyaskin, Md.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

3/28/48  
(month) (day) (year)

Cemetery or crematory

Nanticoke Cem.

Location

near Gesters store

18. Funeral director

C. E. Messick

Address

Bivalve, Md.

19.

Mar 27 48  
(Date rec'd by registrar)

19

48R. M. Walter  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948 at 7:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 March 48 to 25 March 48and that I last saw him alive on 25 March 48

Immediate cause of death

Hypostatic Pneumonia

DURATION

1 week.

Due to

Chronic Ischemic Heart Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. M. Walter

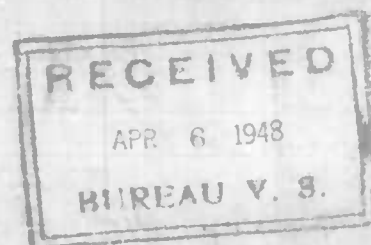
M. D. or other

Address

Nanticoke

Date signed

26 March 48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

03224

X/336

## 1. PLACE OF DEATH:

County NeenicoCity or town Seemar  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 yearsHospital, institution, or street address where death occurred: E. State St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County NeenicoCity or town Seemar  
(If outside city or town limits, write RURAL and give nearest town)Street No. E. State St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George Henry Dize

## 3. (b) Social Security Number

4. Sex M5. Color or race W.6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Katherine Dize

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 18548. AGE: Years 93 Months 6 Days 24 If less than one day  
hrs. min.9. Birthplace Crisfield - Somerset - Md  
(Town, county, and state)10. Usual occupation Retired Waterman11. Industry or business Seafarer12. Name George Dize13. Birthplace Crisfield, Md14. Maiden name Charlotte15. Birthplace Crisfield, Md16. Informant Mrs Ernest TrilleAddress Seemar, Md17. Burial Date thereof Mar 11 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Crisfield CemeteryLocation Crisfield, Md18. Funeral director H. Henry BradshawAddress Crisfield, Md

March 9th 48 Harry E. Hudson

(Date rec'd by Registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1948 at 11:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 19 48 to March 9th 19 48and that I last saw him alive on March 9th 19 48Immediate cause of death occlusion of coronary arteryDue to arteriosclerosisDue to 10 yearsOther conditions figuinal keria

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. Schler M.D.Address Seemar Del Date signed 3-9-48

M. D. or other

Date signed 3-9-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 10 1948

BUREAU V. 8.



Reg. Dist. No. 333

**RECEIVED**

MAR 16 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1170

## CERTIFICATE OF DEATH

03225

Reg. Dist. No. 331

1. PLACE OF DEATH: Neomico  
 County Mardela Md R.D.  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State MD County Mie  
 City or town Mardela, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME Samuel L. Echard

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Etta P Echard

6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct 15 1891

8. AGE: Years 66 Months 7 Days 2 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Middlebrook Va

10. Usual occupation Retired Farmer

11. Industry or business

12. Name John B. Echard

13. Birthplace Scotland

14. Maiden name Mary M. Huphries

15. Birthplace New Port Va

16. Informant Charles H Echard

Address Mardela Md

17. Burial Date thereof 3-19-1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mardela

Location Mardela Md

18. Funeral director Gravenor Bros

Address Sharpton Md

19. 3/19-1948 W H Robertson

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948 at 4:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to March 17 1948

and that I last saw him alive on March 16/48

Immediate cause of death arterio sclerosis

DURATION 9 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Gastric Ulcer 4 years

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE W H Robertson M. D. or other

Address Sharpton Md Date signed 3/17/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03226

Reg. Dist. No. 335

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1943

Walter G. Mann

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

19

at

10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h.

survive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

MAR 25 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

03227

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

### 1. PLACE OF DEATH:

County Sevier  
City or town Selma, Ind.  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Sevier General Hospital  
Stay in hospital or inst. (yrs., or mos., or days) 1 day 21 hrs 10 min  
Stay in this community (yrs., or mos., or days) same

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Warrick  
City or town Pocomoke Ward No. 1  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 800 Market St.  
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

William Edward Ennis

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 23 - 1928

8. AGE: Years 19 Months 7 Days 30 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rehoboth Md.  
(Town, county, and state)

10. Usual occupation Garage Service

11. Industry or business

12. Name James E. Ennis

13. Birthplace Warrick Co. Md.

14. Maiden name Mary J. Hudson

15. Birthplace Warrick Co. Md.

16. Informant James E. Ennis

Address Pocomoke City Md.

17. Burial Date thereof 3/24/1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Salem Church, same

Location Pocomoke City, Ind.

18. Funeral director Howard A. Gilb

Address Pocomoke City, Ind.

19. 3/23/48 1948 Harriet E. Johnson Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 22nd 1948 at 5:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22nd 1948, to 19  
and that I last saw him alive on 19

Immediate cause of death

Pulmonary Congestion  
to Pneumonia

DURATION

Due to

Fracture of spine

Due to

1st + 2nd Cervical  
vertebrae

2 days

Other condition

Vaccinations on injury of hand  
+ deep joint

Major findings:

Of operations

Of autopsy

No autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3/20/48

Where did injury occur? 1 mi. N. of Pocomoke City, Warrick Co. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Road

Means of injury Auto - accident Injured at work? No

23. SIGNATURE

W. E. Johnson M.D.  
Medical Examiner

Address Pocomoke City Md. Date signed 3/22/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

RECEIVED  
APR 1 1948  
BUREAU V. S.



Dr. Radmatta

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1952

03228

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County SalisburyCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

P.O. #4 3 days 11 hrs. 25 min

How long in hospital or institution:

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. PO # 4 Johnson Road  
(If rural, give LOCATION)

2. (b) If veteran, name war

## 3. (a) FULL NAME

Darlene Anne Evans

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

June 15-1947

## 8. AGE:

Years

Months

Days

If less than one day

821hrs.min.

## 9. Birthplace

Bishop Maryland(Town, county, and state) Prince Georges Co. Md

## 10. Usual occupation

None

## 11. Industry or business

## FATHER

## 12. Name

Charles Evans

## 13. Birthplace

Prince Georges Co. Md.

## MOTHER

## 14. Maiden name

Evelyn Thomas

## 15. Birthplace

Princetonville Md.

## 16. Informant

Mr. Charles Evans

## Address

PO #4, Salisbury Md.

## 17. Burial, cremation, or removal, Which?

Burial

Date thereof

May 10-48

## Cemetery or crematory

Ever Green Cem

## Location

Berlin Maryland

## 18. Funeral director

Holloman G. Walter R. Holloman

## Address

Salisbury Md.

## 19. Date of death

3/9/48

19

48March10-4810-48

## 20. DATE OF DEATH

March 6th19481038PM1038PM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw deceased on

Immediate cause of death

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

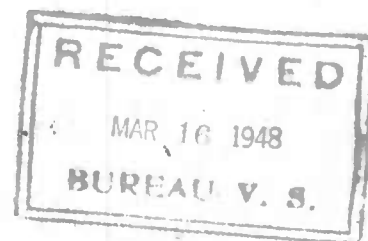
Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.



RECEIVED

MAR 16 1948

BUREAU V. S.

Dr. Whaley

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

03229

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital  
How long in hospital or institution? 16 days 11 hrs. 45 mins.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Rumley  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural, Frenchtown

(If rural, give LOCATION)

2.(a) If veteran, name war \*\*\*\*\*

## 3. (a) FULL NAME

French, Mr. CARROLL CARROLL THOMAS FRENCH

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Viola French6. (c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) January 3, 18948. AGE: Years 54 Months 2 Days 19 If less than one day  
..... hrs. .... min.9. Birthplace Rumley-Somerset-Md.  
(Town, county, and state)10. Usual occupation Waterman11. Industry or business Seafood12. Name John French13. Birthplace Somerset Co., Md.14. Maiden name Hester Blake15. Birthplace Somerset Co., Md.16. Informant Mrs. Viola FrenchAddress Frenchtown, Rumley, Md.17. Burial Burial Date thereof March 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fairmount MethodistLocation Fairmount, Md.18. Funeral director H. Harvey BradshawAddress Crisfield, Md.

3/25 48 R. E. Jones

19. (Date rec'd by registrar) 19 48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22nd 19 48, at 11:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 48, to March 22 19 48  
and that I last saw him alive on March 22 19 48Immediate cause of death Cerebral occlusion DURATION 3 1/2 hrs.

Due to .....

Due to .....

Other conditions Pericarditis 3/5/48

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

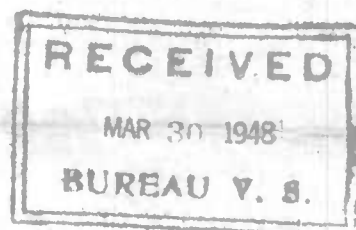
23. SIGNATURE Dr. A. Whaley M.D. or otherAddress P. Anne, Md. Date signed .....

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 30 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03230

## CERTIFICATE OF DEATH

Reg. Dist. No. 330

## 1. PLACE OF DEATH:

County Kicomico  
City or town Mardela Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Md County Kic  
City or town Mardela Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Benjamin H. Graham

## 3. (b) Social Security Number

222-01-64244. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov 16 18828. AGE: Years 65 Months 4 Days 3 If less than one day  
..... hrs. .... min.9. Birthplace Mardela Kic. Md.  
(Town, county, and state)10. Usual occupation Construction Foreman on State Rd

11. Industry or business

12. Name Benjamin H. Graham13. Birthplace Md14. Maiden name Virginia C. Hurley15. Birthplace Md16. Informant Bernice C. MasonAddress Salisbury Md.17. Burial Date thereof 9-22-1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MardelaLocation Mardela Md18. Funeral director Gravesend BrosAddress Sharptown Md.19. 9/22 1948 W.H. Pickett  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 1948 at 2:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on

Feb 1 1948 to Mar 19 1948  
and that I last saw him alive on Mar 19 1948Immediate cause of death acute coronary thrombosis DURATION 1 hourDue to coronary thrombosis 2-3

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE J. H. Lynch M. D. or otherAddress Baltimore Md Date signed 9-20-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 31 1948

BUREAU V. S.

Evidence for change  
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137

03231

FILM No. G 114 MAR 29 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County Wicomico  
City or town Salisbury Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 months  
Hospital, institution, or street address where death occurred:  
Eastern Shore Lbc Soc  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Worcester  
City or town Snow Hill  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 1  
(If rural, give LOCATION)  
2.(a) If veteran, name war no

3. (a) FULL NAME

William Angelo Harris

3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Miss Pearl Harris

7. Birth date of deceased (mo., day, yr.)

Sept 10 1874

6.(c) If alive, give age

69 years

8. AGE:

Years

Months

Days

If less than one day

73

6

4

hrs.

min.

9. Birthplace

Pocomoke Md  
(Town, county, and state)

10. Usual occupation

Farmer & Grocery Store

11. Industry or business

FATHER  
MOTHER

12. Name

Angelo Harris

13. Birthplace

Pocomoke

14. Maiden name

Mary Wilson

15. Birthplace

Pocomoke

16. Informant

Resident's chart

Address

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

March 17/48  
(month) (day) (year)

Cemetery or crematorium

Prince Baptist

Location

Snow Hill 2nd Rural #1

18. Funeral director

Wm B. Smith

Address

Snow Hill, Md

19.

3/15

19. 48

Wm B. Smith

Registrar

23. SIGNATURE

S. H. Kurler

M. D. or other

Address

Salisbury

Date signed 3/14/48

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 14 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/9 1947 to 3/14 1948  
and that I last saw him alive on 3/14 1948

Immediate cause of death

pulmonary tuberculosis

DURATION

5 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

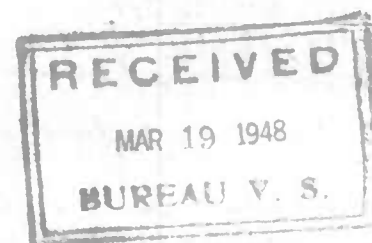
Means of injury Injured at work?

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03232

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
415 Dana Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 417 Smith Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Eva Hayman

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

Ernest Victor Hayman

## 6. (c) If alive, give age

Dead

## 7. Birth date of

deceased (mo., day, yr.)

Sept - 1872

## 8. AGE:

Years 75

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

R.D. Puncen Anne Md.  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

## FATHER

## 12. Name

George Billie Pusey

## 13. Birthplace

R.D. Puncen Anne Md.

## MOTHER

## 14. Maiden name

Elizabeth Brown

## 15. Birthplace

R.D. Puncen Anne Md.

## 16. Informant

Mr. Austin G. Pusey

## Address

423 Smith St. Salisbury Md.

## 17. Burial

Friendship Church Cem.

## 18. Cemetery or crematory

R.D. Puncen Anne Md.

## Location

Hollway & C. Walter R. Hollway

## 19. Funeral director

Salisbury Maryland

## 20. Date of death

March 31 1948

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1937 to March 3 1948

## and that I last saw him

alive on 3-31-48

## Immediate cause of death

Broncho-pneumonia

## Due to

## Due to

## Other conditions

## (Include pregnancy within 8 months of death)

## Major findings of operations

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

## Where did injury occur?

## (City or town)

## (County)

## (State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

George A. Pusey

## M. D. or other

## Address

Salisbury Md.

## Date signed

4-2-48

## 19. (Date rec'd by registrar)

4-1-48

## Registrar

Harriet E. Johnson

## VS A15

## 9-45-15M

## MARGIN RESERVED FOR BINDING

## PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

## is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 13 1948

**BUREAU V. S.**

**RECEIVED**

APR 12 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Peninsula Gen Hosp  
 How long in hospital or institution 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. RFD (Somerset Co.)  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \*\*\*\*\* ✓

## 3. (a) FULL NAME

CLARENCE HAYWARD

## 3. (b) Social Security Number

\*\*\*\*\*

4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
6. (b) Name of husband or wife <u>*****</u>		
7. Birth date of deceased (mo., day, yr.) <u>February 23, 1943</u>		
8. AGE: Years <u>5</u>	Months <u>1</u>	Days <u>25</u> hrs. min.
9. Birthplace <u>RFD Pocomoke-Somerset-Md</u> (Town, county, and state)		
10. Usual occupation <u>None</u>		
11. Industry or business <u>None</u>		
FATHER	12. Name <u>Clarence Hayward</u>	
	13. Birthplace <u>Somerset Co., Md.</u>	
MOTHER	14. Maiden name <u>Betty Webster</u>	
	15. Birthplace <u>Worcester Co., Md.</u>	
16. Informant <u>Clarence Hayward</u>		
Address <u>Pocomoke, Md. (RFD)</u>		
17. (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>March 21, 1948</u> (month) (day) (year)		
Cemetery or crematory <u>St. Luke Cemetery</u>		
Location <u>RFD Pocomoke, Md.</u>		
18. Funeral director <u>H. Harvey Bradshaw</u>		
Address <u>Pocomoke, Md.</u>		
19. <u>3/20</u> (Date rec'd by registrar)		

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1948 at 9:51 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 to 19 and that I last saw him alive on 18

Immediate cause of death Fractured skull

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 3/17/48  
 Where did injury occur? West of Pocomoke (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Public place  
 Means of injury Auto Injured at work? No

23. SIGNATURE W. H. Bradshaw M. D. or other \_\_\_\_\_  
 Address Pocomoke, Md. Date signed 3/18/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hosp.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury, Zion Rd.  
(If outside city or town limits, write RURAL and give nearest town)Street No. RD #3

(If rural, give LOCATION)

2(a) If veteran, name was

3. (b) Social Security Number

## 3. (a) FULL NAME

Hughes, Mrs. William

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Mrs. Mary Ann Hughes

7. Birth date of deceased (mo., day, yr.)

July 18-1926

8. AGE:

21 Years 8 Months 8 Days hrs. min.

9. Birthplace

Wicomico Md.  
(Town, county, and state)

10. Usual occupation

Rooper

11. Industry or business

William H. Hughes

12. Name

William H. Hughes

13. Birthplace

Wicomico Md.

14. Maiden name

Mildred Elliott

15. Birthplace

Wicomico Md.

16. Informant's

Mrs. Mary Ann Hughes

Address

RD #3 Salisbury Md.

17. Burial

March 30-48

(Burial, cremation, or removal) Which?

Wicomico's Mem. Park

Cemetery or crematory

Salisbury Md.

Location

William H. Hughes

18. Funeral director

Salisbury Md.

Address

5/30/48

(Date read by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 48 at 8 42 P M21. I CERTIFY that death occurred on the date above stated; that William H. Hughesand that I last saw him alive on 19 48

Immediate cause of death

Ruptured Bladderfractured pelvisother seriouswound

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

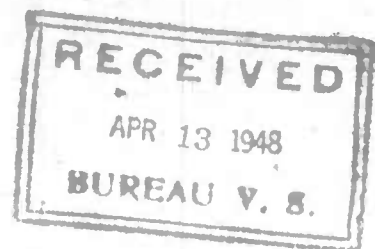
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3/26/48Where did injury occur? East Island Road (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of injury Struck by truck Injured at work? YesSignature Henry M. Lankford M.D.Address Princess Anne Md.Date signed 3/27/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

### 1. PLACE OF DEATH:

County WICOMICO  
City or town RURAL SALISBURY  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 MONTHS  
Hospital, institution, or street address where death occurred:  
HILL TOP CONVALESCENCE HOME  
How long in hospital or institution? 6 MONTHS

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State DELAWARE County SUSSEX  
City or town SEAFORD  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ARCH STREET  
(If rural, give LOCATION)  
2.(a) If veteran, name war. ☒

### 3. (a) FULL NAME

WILLIE SCOTT HURLEY

### 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED

6.(b) Name of husband or wife L. WILBUR HURLEY

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 11, 1859 6.(c) If alive, give age 88 years

8. AGE: Years 88 Months 5 Days 27 If less than one day hrs. min.

9. Birthplace SEAFORD, SUSSEX, DELAWARE  
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business OWN HOME

12. Name JOHN SCOTT

13. Birthplace SEAFORD, DELAWARE

14. Maiden name JANE BAILEY

15. Birthplace UNKNOWN, MARYLAND

16. Informant WILBUR HURLEY

Address BETHEL, DELAWARE

17. BURIAL Date thereof MAR. 9, 1948  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory ODD FELLOWS CEMETERY

Location SEAFORD, DELAWARE

18. Funeral director MEDFORD L. WATSON JR.

Address SEAFORD, DELAWARE

19. 3/8 19 48 Registrar Harriet L. Johnson  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1948 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1947 to March 7, 1948 and that I last saw ex alive on March 6, 1948

Immediate cause of death Chronic Myocarditis

Due to Interconduction

Due to Interconduction

Other conditions Interconduction

(Include pregnancy within 3 months of death)

Major findings of operations Interconduction

Date of op. Interconduction

Autopsy results Interconduction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Interconduction Date of Interconduction

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Interconduction Injured at work?

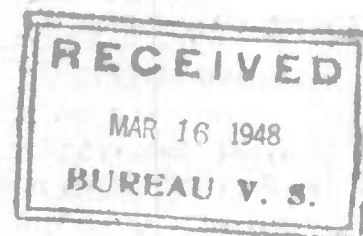
23. SIGNATURE L. P. Prange M.D.

Address Salisbury, Md. Date signed 3/7/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Dr. Inley.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

03236

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:  
R.O. #4

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.O. #4  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eliha William Johnson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Sadie A. Johnson

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1888 6.(c) If alive, give age 57 years

8. AGE: Years 60 Months 0 Days 15 If less than one day  
.....hrs. ....min.

9. Birthplace R.O. #4 - Salisbury Md.  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name John E. Johnson

13. Birthplace Wic. Co. Md.

14. Maiden name Margaret Mc. Allister

15. Birthplace Wic. Co. Md.

16. Informant Mrs. Sadie A. Johnson

Address R.O. #4, Salisbury Md.

17. Burial Date thereof Mar. 9-48  
(Burial, cremation, or reburial. Which?) (month) (day) (year)

Cemetery or crematorium Parson's Cem.

Location Salisbury Md.

18. Funeral director William R. Holloman

Address Salisbury Md.

19. 3/9 19 48 Registrar Dr. Inley  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7<sup>th</sup> 1948 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1948 to March 7, 1948 and that I last saw him alive on March 2, 1948

Immediate cause of death Coronary thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Flora A. Inley M. D. or other

Address Salisbury Md. Date signed 3-9-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

03237

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WICOMICO  
 City or town SALISBURY, MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 YRS  
 Hospital, institution, or street address where death occurred:  
SOUTH PARK DRIVE  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County WICOMICO  
 City or town SALISBURY, MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 505 SMITH ST  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

KAMANITZ, A. DANIEL

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced SINGLE  
 6.(b) Name of husband or wife [REDACTED]  
 7. Birth date of deceased (mo., day, yr.) DEC 23, 1944  
 8. AGE: Years 3 Months 2 Days 22 If less than one day - hrs. - min.

9. Birthplace SALISBURY WICOMICO MD  
 (Town, county, and state)

10. Usual occupation -

11. Industry or business -

12. Name IRVIN L. KAMANITZ  
 13. Birthplace SALISBURY, MD  
 14. Maiden name IDA D. GIVARZ  
 15. Birthplace PICOMONE CITY, MD

16. Informant IRVIN L. KAMANITZ  
 Address SALISBURY, MD

17. BURIAL Date thereof March 23, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Bethesda Cemetery  
 Location Baltimore, Md.

18. Funeral director The Hall & Johnson Co.  
 Address Salisbury, Md.

19. 3/22, 1948 Registrar Harriet L. Johnson  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948 at 12 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from model it 1948  
 and that I last saw him live on 1948

Immediate cause of death straining

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3/22/48

Where did injury occur? Salisbury, Wicomico (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) River

Means of Injury Fell into river Injured at work? no

23. SIGNATURE Dr. [Signature] M. D. or other

Address Salisbury, Md. Date signed 3/22/48

**RECEIVED**

APR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

03238

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Kelly Mr. Claude

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Kelly Mrs. Mary7. Birth date of deceased (mo., day, yr.) January 30, 1878 6. (c) If alive, give age 60 years8. AGE: Years 70 Months 1 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Accomac, Accomac, Virginia  
(Town, county, and state)10. Usual occupation Public Accountant

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Wm. Herman HowardAddress Salisbury, Md.17. Burial Date thereof 3/16/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Edge Wood CemeteryLocation Accomac Va.18. Funeral director Jerry H. WatsonAddress Pocomoke City, Md.19. 3/16 19 48 Registrar Robert R. Starr Address Salisbury Date signed 3-15-48

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 48 at 11:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 4 19 48 to Mar. 15 19 48 and that I last saw him alive on Mar. 15 19 48Immediate cause of death Respiratory failure DURATIONDue to Lobar Pneumonia 7-10 days

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Lobar Pneumonia (chronic type)PHYSICIAN: Please underline the cause to which death should be charged statistically (Lobar Pneumonia)

22. VIOLENCE: If death was due to external causes, fill in the following:

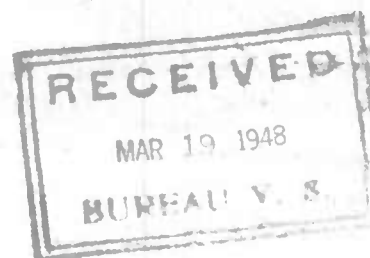
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert R. Starr M. D. other \_\_\_\_\_Address Salisbury Date signed 3-15-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03239

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County McComie  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County McComie  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 603 Camden Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Pauline Kociubinska

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Symon Kociubinska  
 6.(c) If alive, give age deceased years  
 7. Birth date of deceased (mo., day, yr.) April 16, 1878  
 8. AGE: Years 69 Months 10 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ukraine Russia  
 (Town, county, and state)  
 10. Usual occupation Housewife

11. Industry or business at home

FATHER 12. Name Joseph Grochowsky  
 13. Birthplace Russia

MOTHER 14. Maiden name Anna Grochowsky  
 15. Birthplace Russia

16. Informant Patricia N. Casanova  
 Address 603 Camden Ave Salisbury Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Mar 29 1948  
 (month) (day) (year)  
 Cemetery or crematorium McComie Memorial Park

Location Salisbury Md  
 18. Funeral director Holloway & Co. Phone 461

Address Church St Salisbury Md

19. 3/29/48 19 48 Registrar Harriet E. Johnson  
 (Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd 1948 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 47 to March 19 48  
 and that I last saw him alive on March 23 19 48

Immediate cause of death Coronary Vessel Occlusion DURATION 1 wk.

Due to Arteriosclerotic Heart Dis.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Cause of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Lee L. Lawrence MD  
 M. D. or other \_\_\_\_\_

Address Freight Date signed 3-25-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1948

BUREAU V. S.



Dr. Insley

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03240

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For infants born in hospital, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date received by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 46, to March 24 19. 48

and that I last saw him/her alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 393

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Willards  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: ✓  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Wicomico  
 City or town Willards  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no number  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife J. Staton Littleton  
 7. Birth date of deceased (mo., day, yr.) Aug 20, 1874 6.(c) If alive, give age — years

8. AGE: Years 73 Months 7 Days 5 If less than one day — hrs. — min.

9. Birthplace Willards, Md.  
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Housework

FATHER 12. Name David Short

13. Birthplace Md.

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Orlie Lewis  
 Address Willards, Md.

17. Burial Burial Date thereof March 28, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory New Hope  
 Location Willards, Md.

18. Funeral director M. Pasha Watson  
 Address Silhouette, Del.

19. 3/26, 19 48 Harriet E. Johnson Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25-48, 19 —, at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1947, 19 —, to day of death and that I last saw her alive on 3-25-48, 19 —

Immediate cause of death Chronic myocarditis DURATION 6 yrs

Due to —

Due to —

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Frank Lewis M.D. M. D. or other

Address Willards Md. Date signed 3-25-48

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APR 13 1948

BUREAU V. S.

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APR 13 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03242

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH  
County McComie  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
609 S. Division St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD. County McComie  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 609 S. Division St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Annie M. Livingston

3. (b) Social Security Number

4. Sex female  
5. Color or race White  
6. (a) Single, married, widowed, or divorced Widow  
6. (b) Name of husband or wife Washington Robby Livingston  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, year) Sept. 25 - 1872

8. AGE: Years 75 Months 5 Days 9  
If less than one day hrs. min.

9. Birthplace Montgomery County Md.  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business William Brown

12. Name William Brown

13. Birthplace McComie Co. Md.

14. Maiden name Rebecca Brown

15. Birthplace McComie Co. Md.

16. Informant Mr. Horace E. Culver

Address 609 S. Division St. Salisbury Md.

17. Burial (Burial, cremation, or removal) Which? Burial  
Date thereof March 7 - 1948  
(month) (day) (year)  
Cemetery or crematory Union M. Church Cem.  
Location R.D. Salisbury Maryland  
18. Funeral director William R. Hollings  
Address Salisbury Maryland

19. (Date rec'd by registrar) 3/16/48  
Registrar W. H. Johnson

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948 at 1203 PM

CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1948 at 1203 PM  
and that I last saw deceased alive on March 4 1948 at 1203 PM  
Immediate cause of death Coronary occlusion

Due to Coronary occlusion

Due to Coronary occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following: No  
Accident, suicide, or homicide Date of No

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

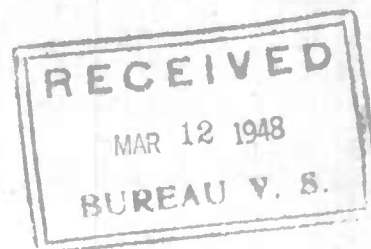
23. SIGNATURE W. H. Johnson  
M. D. or other

Address Salisbury Md. Date signed 3/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Gramse

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03243

## CERTIFICATE OF DEATH

Reg. Dist. No. 533

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 23 days, 4 hrs., 30 mins.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Sei Hand  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Long, Thomas

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 19168. AGE: Years 32 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Rockingham (N.C.)  
(Town, county, and state)10. Usual occupation laborer

## 11. Industry or business

12. Name John W. Long13. Birthplace Rockingham N.C.14. Maiden name Bell Barnes15. Birthplace Rockingham N.C.16. Informant Geed FinclairAddress 22 S. William17. burial Date thereof March 21, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory RockinghamLocation Rockingham N.C.18. Funeral director Charles H. WardAddress Marion Sta ind19. 3/22, 1948 Registrar John

(Date rec'd by registry)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 19 48 at 8 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 47 to March 21 19 48  
and that I last saw him alive on 3-21 19 48Immediate cause of death PneumoniaDue to Gastric resection & enterostomy

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Pyloric stenosis due to  
peptic ulcer Date of op. 3/3/48

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE L.R. Gramse M.D.Address Salisbury Md Date signed 3/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 1 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

03244

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Pennamula General Hospital*  
 County: *W. Carroll*  
 City or town: *Salisbury*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
*Pennamula General Hospital*  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: *Maryland* County: *Harveston*  
 City or town: *Stockton*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war:

3. (a) FULL NAME *Martin, Frank*

3. (b) Social Security Number

4. Sex *M* 5. Color or race *C* 6. (a) Single, married, widowed, or divorced *1st*  
 6. (b) Name of husband or wife *Janice Tull*  
 7. Birth date of deceased (mo., day, yr.) *April 1, 1918* 6. (c) If alive, give age years  
 8. AGE: Years *28* Months *11* Days *7* If less than one day hrs. min.

9. Birthplace: *Girdletree, Md.* (Town, county, and state)  
 10. Usual occupation *Waterman*  
 11. Industry or business *Sea food*  
 FATHER 12. Name *Harry Martin*  
 13. Birthplace *Girdletree*  
 MOTHER 14. Maiden name *Bertha Fisher*  
 15. Birthplace *Stockton*

16. Informant: *Clement Martin*  
 Address *Stockton, Md.*  
 17. Burial Date thereof: *Mar. 11, 1948*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory *Home Beneficial Cemetery*  
 Location *Stockton, Maryland*  
 19. Funeral director *H. Harvey Bradshaw*  
 Address *Pocomoke City Md.*

19. *3/10* 19 *48* Registrar *H. Harvey Bradshaw*  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 8th* 19 *48* at *9:25* AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1:30 PM 3/8* 19 *48*  
 and that I last saw him *3/8/48* 19  
 Immediate cause of death: *operation for tumor*  
 Due to: *operation for tumor*  
 Due to: *Bleeding from tumor*  
 Other conditions: *Traumatic Peritonitis*  
 (Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide *Homicide* Date of *3/7/48*  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury *Shot* Injured at work?

23. SIGNATURE *H. S. Gorton M.D.*  
 Address *Pocomoke City, Md.* Date signed *3/8/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

454

03245

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 and 3/4 hours  
 Hospital, institution, or street address where death occurred:  
Peninsula General Hospital  
 How long in hospital or institution? 4 and 3/4 hours.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

McDaniel Mrs Rose Pearl

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband Arthur E. McDaniel  
 7. Birth date of deceased (mo., day, yr.) June 16, 1884 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 63 Months 9 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Westover, Somerset Co. Md.  
(Town, county, and state)10. Usual occupation House Wife

## 11. Industry or business

FATHER 12. Name Robert H. Dryden  
 13. Birthplace Somerset County Maryland  
 MOTHER 14. Maiden name Mary Jane Dryden  
 15. Birthplace Somerset County Maryland

16. Informant Mr Arthur E. McDanielAddress Pocomoke city, Maryland17. Burial Date thereof 3/21/1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Salern Church Cem.Location Pocomoke city, Md.18. Funeral director Howard A. GillAddress Pocomoke city, Md.19. 3/19 1948 Robert H. Dryden  
(Date read by registry) (year) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1948 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18, 6:30 P.M. 1948 to March 18, 10:30 P.M. 1948  
 and that I last saw her alive on March 18, 1948

Immediate cause of death Hemorrhage, Decaying DURATION 5 hours  
Carcinoma Right Breast 1 1/2 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William B. Long M.D.  
M. D. or otherAddress 504 N. Division St. Date signed March 19, 1948  
Salisbury Md.

**RECEIVED**

APR 2 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03246

Reg. Dist. No. 11336

### 1. PLACE OF DEATH:

County Wicomico  
City or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 years  
Hospital, institution, or street address where death occurred:  
207 East St  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Wicomico  
City or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 207 East St  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Amelia Ann Nelson

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Elmer John Nelson  
7. Birth date of deceased (mo., day, yr.) Dec 3 - 1860 6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 87 Months 3 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Delmar, Del  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business None

12. Name Mr. Elmer

13. Birthplace Delmar, Del

14. Maiden name Amelia Jane Gandy

15. Birthplace Delmar, Del

16. Informant Katie Hastings

Address Delmar Del

17. Burial Date thereof 3-4-48  
(Burial, Which?) (month) (day) (year)

Cemetery of St. John's

Location Delmar Del

18. Funeral director W. S. Marvel Co

Address Delmar Del

19. March 4, 1948 Harry E. Hudson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948 at 12:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1947 to Mar 2 1948

and that I last saw him live on Mar 1 1948

Immediate cause of death Thrombosis

Due to Thrombosis

Due to Pulmonary Disease

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. H. Nelson M. D. or other \_\_\_\_\_

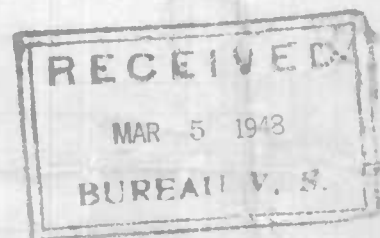
Address Delmar, Del. Date signed 3-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Rademaker

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

03247

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Josephine Miciotto

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Pietro Miciotto

7. Birth date of

deceased (mo., day, yr.)

March 19-1879

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

6904hrs.min.

&lt;

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APR 13 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1960

03248

## CERTIFICATE OF DEATH

Reg. Dist. No. 433

## 1. PLACE OF DEATH:

County... HarfordCity or town... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 9 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... McComickCity or town... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 315 Race  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Niblett, Mr. James(James Sanford Niblett)

(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(g) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Florea B. Niblett

7. Birth date of

deceased (mo., day, yr.)

Dec. 1st 1908(c) If alive, give age 39 years

8. AGE:

Years

Months

Days

If less than one day

39319

hrs.

min.

9. Birthplace

Laurel Delaware

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal)

18. Cemetery or crematory

19. Location

20. Funeral director

Address

21. Signature

Address

22. Date signed

23. Address

24. Date signed

25. Address

26. Date signed

27. Address

28. Date signed

29. Address

30. Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 2019 48

at

7:23 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw expired alive on March 19 19 48

Immediate cause of death

Brain injury  
Fractured skull

DURATION

9 hrs  
9 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident ? Date of 3/19/48Where did injury occur? Salisbury McComick MD  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) StreetMeans of injury fell against Injured at work? No

23. SIGNATURE

Dr. RademakerAddress Salisbury Date signed 3/20/48

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APR 1 1948

BUREAU V. S.

Dr. Gramse

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03249

## CERTIFICATE OF DEATH

Reg. Dist. No. 939

## 1. PLACE OF DEATH:

County PriconicCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pen. Gen. Hosp.

How long in hospital or institution?

3. (a) FULL NAME

Mary Elizabeth Tiftlett (or, Mamie E. Tiftlett)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County PriconicCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1107 Railroad Ave.

(If rural, give LOCATION)

(g) If veteran, name war.

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William Alfred Tiftlett

7. Birth date of

deceased (mo., day, yr.)

Feb. 5 - 1905

6. (c) If alive, give age

47 years

8. AGE:

Years 43 Months 1 Days 15 hrs. min.

9. Birthplace

Salisbury Maryland  
(Town, county, and state)

10. Usual occupation

Home at home

11. Industry or business

Charles S. Davis

12. Name

13. Birthplace Laurel Delaware

14. Maiden name

Sadie Layfield

15. Birthplace

Salisbury Md.

16. Informant

W. A. Tiftlett

Address

1107 Railroad Ave. Salisbury Md.

17. (Burial, cremation, or other)

Buried Date thereof March 22, 1948  
(month) (day) (year)

Cemetery or crematorium

Priconic Cem.

Location

Salisbury Maryland

18. Funeral director

William R. Tiftlett R. Tiftlett

Address

Salisbury Md.

19. (Date rec'd by registrar)

3/22/48 1948 Registrar W. R. Tiftlett

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20<sup>th</sup> 1948 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1947 to March 20 1948and that I last saw him alive on March 20 1948

Immediate cause of death

Myocardial

Due to

Chronic Hypertension

Due to

Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. R. Gramse MDAddress Salisbury Md. Date signed 3/20/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03253

## CERTIFICATE OF DEATH

Reg. Dist. No. 939

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Peninsula General Hospital

How long in hospital or institution? 2 days, 9 hrs, 35 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_ ☒

## 3. (a) FULL NAME

Pappi Barbabe Mrs. Edith

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife

Joseph Pappi

7. Birth date of deceased (mo., day, yr.)

May 11, 1885

8.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

62 Years

Months

919 Days

If less than one day

hrs. min.

9. Birthplace

Snow Hill, Md.  
(Town, county, and State)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Sidney Long

13. Birthplace

Md.

MOTHER

14. Maiden name

Naomi Dryden

15. Birthplace

Md.

16. Informant

Mrs. Clarence Long

Address

Crisfield and

17. (Burial, cremation, or removal. Which?)

Date thereof

4/1/48  
(month) (day) (year)

Cemetery or crematory

Bates Memorial

Location

Snow Hill Md.

18. Funeral director

Anna A. Burban

Address

Berlin Md.

19.

4/1/48  
(Date filed by registrar)

19.

48111111111111111111

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 48 at 2 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

March 27 19 48 to March 30 19 48and that I last saw him alive on March 29 19 48

Immediate cause of death

diabetic Acidosis  
(Cause)diabetes Mellitus10 yrs.4 daysCentral Thrombosis4 daysMajor findings of operationsAutopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work \_\_\_\_\_

David Gilman M.D.4/1/48Salisbury4/1/48

**RECEIVED**

APR 13 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

03250

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County HeardCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County McernicoCity or town Paromety  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Parsons, Mrs. Edward L.

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Walter Parson

7. Birth date of

deceased (mo., day, yr.)

July 23-1914

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 33 Months 7 Days 14 hrs. \_\_\_\_\_ min.

9. Birthplace

RD. Paromety Md  
(Town, county, and state)

10. Usual occupation

Auto Mechanic

11. Industry or business

Food Service Center

12. Name

John William Parson

13. Birthplace

Paromety, Md.

14. Maiden name

Judith Parson

15. Birthplace

Mt. Vernon Maryland

16. Informant

Mrs. Helen Parson

17. Address

Paromety Md.

18. Cemetery

Bethel Church Cem.

19. Location

Mt. Vernon Maryland

20. Funeral director

William C. Miller R. Miller

21. Address

Salisbury Md.

22. Date

3/10/48

23. Registrar

Walter R. Miller

24. Address

Salisbury Md.

25. Date signed

3/9/48

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948 at 2:40 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on March 7 1948

Immediate cause of death

Fractured skull  
Brain injury

DURATION

1 1/4 hrs  
1 1/4 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

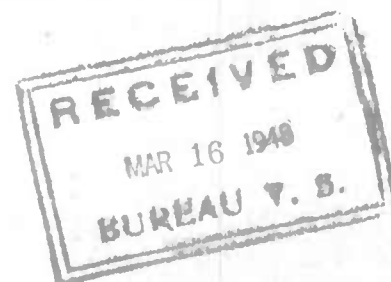
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3/6/48Where did injury occur? Salisbury Wicomico Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) StreetMeans of Injury Collided with freight truck Injured at work? No23. SIGNATURE Walter R. Miller M. D. or otherAddress Salisbury Md Date signed 3/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Rodamaker M.D.

Evidence for change of age shown on!

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

03251

FILM No. G 114 MAR 17 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH:

County Wicomico County  
City or town Parsonsbury, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life time  
Hospital, institution, or street address where death occurred:  
at home  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Wicomico Co  
City or town Parsonsbury, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

Henrietta Parsons

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Sandy Parsons  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) May 1, 1879  
8. AGE: Years 68 Months 5 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Parsonsbury, Md.  
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business none

FATHER 12. Name John Blake

13. Birthplace Parsonsbury, Md.

MOTHER 14. Maiden name Elyse Parnell

15. Birthplace Parsonsbury, Md.

16. Informant Sandy Parsons

Address Parsonsbury, Md.

17. Burial, cremation, or removal, Which? Burial Date thereof Mar 4, 1948  
(month) (day) (year)

Cemetery or crematory Glenn Hill Cem.

Location Parsonsbury, Md.

18. Funeral director Booker M. West

Address Salisbury Md.

19. 3/4 19 48 W. B. Basset Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 19 48 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw the deceased alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Coronary occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op. \_\_\_\_\_

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. Rodamaker M.D. M. D. or other \_\_\_\_\_

Address Salisbury Md. Date signed 3/3/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line to left of age is especially important. Physicians: Please write the causes of death clearly and legibly.

**RECEIVED**

MAR 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EVIDENCE FOR CHANGE OF MARYLAND STATE DEPARTMENT OF HEALTH  
AGE & BIRTHDATE SHOWN ON:  
FILM NO. G 115 APR 27 1948 CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore

03252

Reg. Dist. No. 11 336

## 1. PLACE OF DEATH:

County DelawareCity or town Delmar, Del.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 monthsHospital, institution, or street address where death occurred:  
noneHow long in hospital or institution? none

## 3. (a) FULL NAME

Mary E. Pettyjohn4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Rev M J Pettyjohn

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Nov 7 2 1984 19848. AGE: Years 63 Months 4 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Del. Milton Del.  
(Town, county, and state)10. Usual occupation House Wife

## 11. Industry or business

12. Name Henry Hazard13. Birthplace Delaware14. Maiden name Martha Carr15. Birthplace Del.16. Informant Rev M J PettyjohnAddress Delmar Del.17. (Burial, cremation, or removal, Which?) March 30 1948  
(month) (day) (year)Cemetery or crematory Bethel Cemetery Milton Del.Location Milton Del.16. Funeral director Calvin BlairAddress 102 So Green St Dover Del.19. 3-26-48 19 Harry E Hudson  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County DelawareCity or town Delmar Del.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2. (a) If veteran, name war none

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 48 539 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 47 to March 26 19 48and that I last saw him or alive on March 26 19 48Immediate cause of death Cancer bladder

## DURATION

6 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Toxemia from decu - 2 weeksbitus infectedHead of leg from 10 weeks

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of January 12, 1948Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury slipped on rug and fell Injured at work? \_\_\_\_\_23. SIGNATURE A. V. Schler M.D. M. D. or other \_\_\_\_\_Address Delmar Del. Date signed 3-26-48

RECEIVED

MAR 29 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03254

## CERTIFICATE OF DEATH

Reg. Dist. No. 3.73

D. Gray

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 21 hrs. 15 mins.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Willards  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Smallwood, Mrs. Kate

## 3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Harry Smallwood7. Birth date of deceased (mo., day, yr.) April Sept 26, 1874 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Willards, Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business 1112. Name Unknown13. Birthplace Unknown14. Maiden name Mother Smith15. Birthplace Md.16. Informant Harry SmallwoodAddress Willards Md.17. Burial Date thereof 3/21/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Evergreen CemeteryLocation Beulah, Md.18. Funeral director M. Pasha WatsonAddress Salisbury, Del.19. 3/19/48 Registrar Harriet B. Johnson

(Date signed by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 19 48 at 5:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 19 48 to March 18 19 48and that I last saw her alive on March 18 19 48Immediate cause of death Acute congestive failureDue to Coronary thrombosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William D. Gray, M.D.Address Salisbury, Md. Date signed 3/18/48

Address \_\_\_\_\_ Date signed \_\_\_\_\_

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wisconsin  
 City or town Salsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred: ✓  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
 City or town Bishopville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1720  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Swift Mr. Edward Henry

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced divorced  
 6.(b) Name of husband or wife Unknown  
 7. Birth date of deceased (mo., day, yr.) March 6, 1913 6.(c) If alive, give age 35 years  
 8. AGE: Years 35 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Bishopville, S.C.  
 (Town, county, and state)

10. Usual occupation Trucker

11. Industry or business Truck driver

12. Name Gordy Swift

13. Birthplace Mad.

14. Maiden name Jessie Boring

15. Birthplace S.C.

16. Informant Mr. Gordy Swift

Address Bishop, Md.

17. Burial Date thereof March 8, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory g. o. o. s.

Location Bishopville, S.C.

18. Funeral director Mr. Paul Watson

Address Schuyler, S.C.

19. 3/7/48 19 48 Barrett E. Johnson  
 (Date) (d by) (year) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 48 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1948 to 1948

and that I last saw h. on March 6, 1948

Immediate cause of death Coronary thrombosis

Due to Deadly

Due to Deadly

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3/6/48

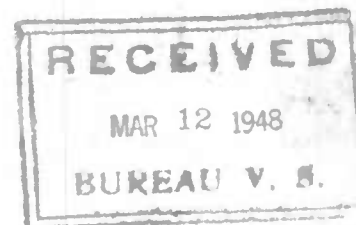
Where did injury occur? Salsburg (City or town) Worcester (County) MD (State)

Injured at home, farm, industry, public place (where?) Falling station

Means of injury Went to stop in truck and a motor running Injured at work? No

23. SIGNATURE Barrett E. Johnson Registrar

Address Salsburg, Md. Date signed 3/6/48



MARGIN RESERVED FOR BINDING





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03256

Reg. Dist. No. 333

### 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital  
How long in hospital or institution? Four days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico  
City or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Shiloh Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Torry, Mr. Harry Albert

### 3. (b) Social Security Number

4. Sex Male 5. Color White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Marie Piddish Torry

7. Birth date of deceased (mo., day, yr.) March 14 - 1892 6.(c) If alive, give age Dead years

8. AGE: Years 56 Months 0 Days 15 If less than one day hrs. min.

9. Birthplace Edinboro, Pa.  
(If county and state)

10. Usual occupation State Health Inspector

11. Industry or business of Remount Co. Dpt.

12. Name Albert Torry

13. Birthplace Edinboro, Pa.

14. Maiden name Elinore Vogue

15. Birthplace Oil City, Pa.

16. Informant Mrs. Nellie J. a. Buchwald

Address 4263 Rut 48th St. Cleveland Ohio

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof April 1 - 1948  
(month) (day) (year)

Cemetery or crematory Wicomico Mem. Park

Location Salisbury Maryland

18. Funeral director Holloman & Co. Walter R. Holloman  
Address Salisbury Md.

19. Date rec'd by registrar 4/1/48 19 48 Registrar Barbara L. Johnson

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 48 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 48 to 3-29- 19 48  
and that I last saw him alive on 3-29- 19 48

Immediate cause of death Acute congestive heart failure

Due to Myocarditis

Due to Pneumonia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE L.R. Granger M.D. M. D. or other

Address Salisbury Md. Date signed 3-29-48

RECEIVED

APR 13 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

03257

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 yrs  
 Hospital, institution, or street address where death occurred:  
208 E. Isabelle St  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 208 E. Isabelle St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war -

## 3. (a) FULL NAME

Maudie R. Goulson

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife John M. Goulson  
 6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) OCT 24, 1883  
 8. AGE: Years 64 Months 3 Days 6 If less than one day - hrs. - min.

9. Birthplace Chester, Md  
 (Town, county, and state)

10. Usual occupation Postmaster

11. Industry or business -

12. Name Josiah Ringgold

13. Birthplace Chester, Md

14. Maiden name Clementine Pierce

15. Birthplace Chester, Md

16. Informant Kenneth J. Sigworth

Address Normal, Tenn.

17. Burial Date thereof April 1, 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Parsons

Location Salisbury, Md

18. Funeral director Full & Johnson Co

Address Salisbury, Md.

19. 4/11 19 48 Kenneth J. Sigworth  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30 19 48 at 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 27 19 47, to Mar. 30 19 48, and that I last saw him alive on March 30 19 48

Immediate cause of death Carcinoma of breast.

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work -

23. SIGNATURE Flora A. Goulson M. D. 4/3/48

Address Salisbury, Md. Date signed 4/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 12 1948

BUREAU V. S.



RECEIVED

MAR 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1060

03259

## CERTIFICATE OF DEATH

Reg. Diat. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred:  
Peninsula General Hospital  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Worcester  
 City or town Ocean City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war. \_\_\_\_\_

## 3. (a) FULL NAME

WATSON, DONALD JAMES

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) April 30, 1947  
 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years \_\_\_\_\_ Months 10 Days 17 less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland Wic.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Richard L. Watson13. Birthplace MD14. Maiden name Maria Catherine Allen15. Birthplace New Jersey16. Informant Richard L. WatsonAddress Ocean City, MD17. burial Date thereof 3/10/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Seaside, Md.18. Funeral director James A. LuskAddress Seaside, Md.19. 3/21 1948  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/10 1948 to 3-13-48 1948  
 and that I last saw him alive on 3-13-48 1948

Immediate cause of death Larynx - Cancer  
Bronchitis

## DURATION

3 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert Gore

M. D. or other

Address Seaside, Md.Date signed 3-11-48

**RECEIVED**

APR 2 1948

**BUREAU V. 8.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1579

03260

## CERTIFICATE OF DEATH

Reg. Dist. No. 260-333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred:  
Peninsula General Hospital  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Somerset  
 City or town Princess Anne  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Beechwood Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

David Webster, Jr.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 1, 1948  
 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 15 hr. \_\_\_\_\_ min.

9. Birthplace Peninsula General Hospital Salisbury, Md.  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name David Webster  
 13. Birthplace Somerset County

14. Maiden name Peggy Simpkins  
 15. Birthplace Somerset County

16. Informant David Webster  
 Address Princess Anne, Md.

17. Burial Date thereof 3-15-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Asbury Church  
Mt. Vernon, Md.

Location Mt. Vernon, Md.

18. Funeral director Wilson Funeral Home  
 Address Princess Anne, Md.

19. 3/16 48 R. D. Johnson, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 48 at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8<sup>th</sup> 19 48 to March 15<sup>th</sup> 19 48  
 and that I last saw him alive on March 14<sup>th</sup> 19 48

Immediate cause of death acidosis DURATION 1 day

Due to maternal child take a Robert fluid

Due to \_\_\_\_\_

Other conditions Partial Pyloric Stenosis (Congenital) Swiss Birth  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

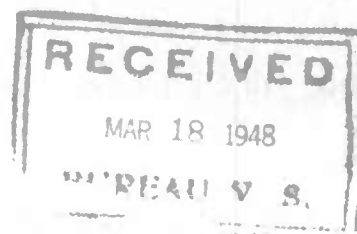
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thos. B. Whaley, M.D. M. D. or other \_\_\_\_\_

Address Princess Anne Date signed 3/15/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03261

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yr.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 208 1/2 Delaware Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sally Whittington  
 4. Sex Fe 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Rachel Whittington

7. Birth date of deceased (mo., day, yr.)

Nov. 25, 1875

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

72325

hrs.

min.

9. Birthplace

Marion Sta., Somerset, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Purnell Henry  
 13. Birthplace Pocomoke City, Maryland  
 14. Maiden name Mrs. Jessie Blackley  
 15. Birthplace White Haven Md.

16. Informant

Threne Bell

Address

208 1/2 Del. St. Salisbury, Md.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

Mar. 3, 1948  
(month) (day) (year)

Cemetery or crematory

Wayman

Location

Marion

18. Funeral director

Charles H. Ward

Address

Marion Sta., Md.

19.

3/80, 1948  
(Date rec'd by registrar)Harriet L. Johnson  
Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 20, 1948 at 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 12, 1948 to Mar. 20, 1948and that I last saw h. Mar. 20 alive on Mar. 20 1948

Immediate cause of death

Coronary occlusion

DURATION

Due to

ArteriosclerosisIndefinite

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Purnell, M.D.

M. D. or other

Address

800 W. Main

Date signed

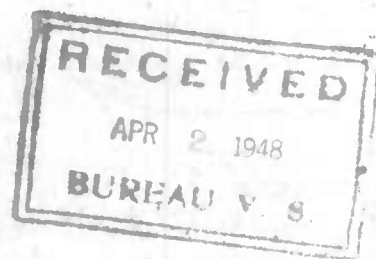
3-28-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 399

### 1. PLACE OF DEATH:

County Wilcomico  
City or town Prutland md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred: no  
How long in hospital or institution? no

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Wilcomico  
City or town Prutland md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. no  
(If rural, give LOCATION)  
2.(a) if veteran, name war no

### 3. (a) FULL NAME

Louise Wright

### 3. (b) Social Security Number

no

4. Sex female 5. Color or race a.g. 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Preston Wright  
yes 6.(c) If alive, give age Don't know years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 Months — Days — If less than one day — hrs. — min.

9. Birthplace Home Quarter md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business same as above

12. Name Josiah Wilson

13. Birthplace Home Quarter md

14. Maiden name Martha Jones

15. Birthplace Prutland md

16. Informant Preston Wright

Address Prutland md

17. Burial Date thereof May 25 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory mt. Calvary

Location Prutland md

18. Funeral director James H. Stewart

Address Baltimore md

19. 3/20 1948 Registrar John

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 48 5:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 48 to March 22 48

and that I last saw him/her alive on March 22 48

Immediate cause of death Pul. Tuberculosis DURATION 23 years

Due to Pul. Tuberculosis

Due to secondary R. Respiratory

Other conditions Chronic Nephritis Heart

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John R. Mann M. D. or other

Address Salisbury md Date signed 3/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

